

		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005090

Facility Name: LUTHERAN HOME FOR THE AGED

Address: 800 WEST OAKTON ARLINGTON HTS 60004

County: COOK

Telephone Number: (847) 253-3710 Fax # (847) 253-1427

IDPA ID Number: 362192824002

Date of Initial License for Current Owners: 8/1/1960

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name:: Steve Lavenda

Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Kenneth W. Huff

(Title) Vice President of Finance

Paid Preparer

(Signed) See Accountants' Compilation Report Attached

(Print Name and Title) Steven N. Lavenda, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001

Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED

0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	252	Skilled (SNF)	252	91,980	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5	167	Sheltered Care (SC)	167	60,955	5
6		ICF/DD 16 or Less			6
7	479	TOTALS	479	174,835	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,218	1,952	9,015	12,185	8
9	SNF/PED					9
10	ICF	33,997	64,850		98,847	10
11	ICF/DD					11
12	SC	1,006	22,099		23,105	12
13	DD 16 OR LESS					13
14	TOTALS	36,221	88,901	9,015	134,137	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.72%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
384 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Adult Day Care, Outpatient Therapy, Child Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 8/1/53

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 252 and days of care provided 8,869

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/02 Fiscal Year: 6/30/02
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **LUTHERAN HOME FOR THE AGED** # **0005090** Report Period Beginning: **07/01/01** Ending: **06/30/02**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,303,052	50,155	4,002	1,357,209		1,357,209	(385,887)	971,322			1
2	Food Purchase		1,609,959		1,609,959		1,609,959	(503,378)	1,106,581			2
3	Housekeeping	793,162	120,719	264,844	1,178,725		1,178,725	(227,607)	951,118			3
4	Laundry	113,354	74,466	68,143	255,963		255,963		255,963			4
5	Heat and Other Utilities			995,179	995,179		995,179	(364,389)	630,790			5
6	Maintenance	772,536	154,653	585,457	1,512,646		1,512,646	(263,175)	1,249,471			6
7	Other (specify):*											7
8	TOTAL General Services	2,982,104	2,009,952	1,917,625	6,909,681		6,909,681	(1,744,436)	5,165,245			8
	B. Health Care and Programs											
9	Medical Director			16,809	16,809		16,809		16,809			9
10	Nursing and Medical Records	8,009,288	477,085	8,847	8,495,220		8,495,220	(7,600)	8,487,620			10
10a	Therapy	170,309	13,022	13,949	197,280		197,280		197,280			10a
11	Activities	323,383	108,255	1,683	433,321		433,321	(48,964)	384,357			11
12	Social Services	219,739	3,060	4,800	227,599		227,599	(4,385)	223,214			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,722,719	601,422	46,088	9,370,229		9,370,229	(60,949)	9,309,280			16
	C. General Administration											
17	Administrative	95,411		4,074,351	4,169,762		4,169,762	(3,660,982)	508,780			17
18	Directors Fees											18
19	Professional Services			251,402	251,402		251,402	7,478	258,880			19
20	Dues, Fees, Subscriptions & Promotions			39,072	39,072		39,072	47,219	86,291			20
21	Clerical & General Office Expenses	177,259	38,850	150,337	366,446		366,446	673,268	1,039,714			21
22	Employee Benefits & Payroll Taxes			922,892	922,892		922,892	1,487,588	2,410,480			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,736	24,736		24,736	10,888	35,624			24
25	Other Admin. Staff Transportation			4,774	4,774		4,774	9,368	14,142			25
26	Insurance-Prop.Liab.Malpractice			238,236	238,236		238,236		238,236			26
27	Other (specify):*							320,199	320,199			27
28	TOTAL General Administration	272,670	38,850	5,705,800	6,017,320		6,017,320	(1,104,974)	4,912,346			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,977,493	2,650,224	7,669,513	22,297,230		22,297,230	(2,910,359)	19,386,871			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,029,000	2,029,000		2,029,000	(46,639)	1,982,361			30
31	Amortization of Pre-Op. & Org.			28,984	28,984		28,984	(28,984)				31
32	Interest			1,467,150	1,467,150		1,467,150	(1,212,473)	254,677			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,533	1,533		1,533		1,533			35
36	Other (specify):*											36
37	TOTAL Ownership			3,526,667	3,526,667		3,526,667	(1,288,096)	2,238,571			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,113,215	1,068,550	2,181,765		2,181,765	(114,195)	2,067,570			39
40	Barber and Beauty Shops	99,951	20,472	405	120,828		120,828	(120,828)				40
41	Coffee and Gift Shops		45,292		45,292		45,292	(45,292)				41
42	Provider Participation Fee			174,765	174,765		174,765	(3,945)	170,820			42
43	Other (specify):*	306,480			306,480		306,480	(306,480)				43
44	TOTAL Special Cost Centers	406,431	1,178,979	1,243,720	2,829,130		2,829,130	(590,740)	2,238,390			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	12,383,924	3,829,203	12,439,900	28,653,027		28,653,027	(4,789,195)	23,863,832			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(62,640)	2		4
5	Telephone, TV & Radio in Resident Rooms	(51,796)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	170,329	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,186)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,036,002)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,050,295)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(738,900)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (738,900)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,789,195)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
LUTHERAN HOME FOR THE AGED			
ID# 0005000			
Report Period Beginning: 07/01/01			
Ending: 06/30/02			
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 Music Income	(5,300)	11	1
2 Misc. Op - Volunteers	(3,034)	21	2
3 Misc. Op - Arts & Crafts	(4,795)	11	3
4 Printing Income - Internal	(1,261)	21	4
5 Senior Fit	(29,463)	11	5
6 Concert Series	(9,406)	11	6
7 Application Fees	(43,100)	21	7
8 Bearing Aid Income	(405)	21	8
9 L.V - Apt Cleaning	(84,796)	3	9
10 L.V - Medical Fees	(7,600)	10	10
11 L.V - Housekeeping / POM	(174,120)	6	11
12 L.V - Security	(27,434)	6	12
13 L.V - Phys - Socials	(4,385)	12	13
14 L.V - Housekeeping	(95,805)	3	14
15 Cable TV	(65,590)	5	15
16 Amortization - LHA	(28,984)	31	16
17 Beauty Shop	(120,828)	40	17
18 Variety Store Supplies	(45,292)	41	18
19 Salaries - Hearthstone - Food Service	(306,400)	42	19
20 Excess Bed Tax	(3,585)	42	20
21			21
22 Non-Care Interest	(565,904)	32	22
23 Investment Income	(668,465)	32	23
24 Non-Care Utilities	(298,350)	5	24
25 Non-Care Housekeeping	(47,066)	3	25
26 Hearthstone - Adult Day Care Dietary	(385,887)	1	26
27 Hearthstone - Adult Day Care Food	(413,499)	2	27
28 Capitalized Repairs & Maintenance	(105,253)	6	28
29 Pharmacy Discounts	(114,195)	39	29
30 Food Discounts	(6,415)	2	30
31 Other Discounts	(4316)	21	31
32 Misc. Income	(801)	21	32
33 Professional Fees - ARK Development	(9000)	19	33
34 Out-of-state Seminar	(10483)	24	34
35 Undocumented Seminar	(1565)	24	35
36 Non-Care Depreciation	(216968)	30	36
37 HRA Dues	(23750)	20	37
38 Non-Care Legal	(402)	19	38
39 Promotional expense	(263)	20	39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(4,036,002)		101

Summary A

06/30/02

[illegible]

Summary B

Facility Name & ID Number	LUTHERAN HOME FOR THE AGED	#	0005090	Report Period Beginning:	07/01/01	Ending:	06/30/02
--------------------------------------	-----------------------------------	----------	----------------	---------------------------------	-----------------	----------------	-----------------

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		Wittenberg Lutheran Village, Inc.	Crown Point, IN	See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☒

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative Allocation	\$ 4,074,351	Lutheran Home and Services for the Aged, Inc.	100.00%	\$	\$ (4,074,351)	15
16	V	2	Food Purchase		Lutheran Home and Services for the Aged, Inc.	100.00%	(824)	(824)	16
17	V	6	Repairs & Maintenance		Lutheran Home and Services for the Aged, Inc.	100.00%	43,640	43,640	17
18	V	17	Administrative		Lutheran Home and Services for the Aged, Inc.	100.00%	413,369	413,369	18
19	V	19	Professional Fees		Lutheran Home and Services for the Aged, Inc.	100.00%	97,880	97,880	19
20	V	20	Dues & Subscriptions		Lutheran Home and Services for the Aged, Inc.	100.00%	71,232	71,232	20
21	V	21	Clerical & General Office		Lutheran Home and Services for the Aged, Inc.	100.00%	848,167	848,167	21
22	V	22	Employee Benefits		Lutheran Home and Services for the Aged, Inc.	100.00%	1,487,588	1,487,588	22
23	V	24	Travel & Seminar		Lutheran Home and Services for the Aged, Inc.	100.00%	22,936	22,936	23
24	V	25	Other Admin. Staff Transportation		Lutheran Home and Services for the Aged, Inc.	100.00%	9,368	9,368	24
25	V	27	Other - Employee Benefits		Lutheran Home and Services for the Aged, Inc.	100.00%	320,199	320,199	25
26	V	32	Interest Expense		Lutheran Home and Services for the Aged, Inc.	100.00%	21,896	21,896	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,074,351			\$ 3,335,451	\$ * (738,900)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Roger Paulsberg	Chairman	Administrative	0	see attached	34	85.00%	alloc. Salary	\$ 99,326	17-7	1
2	Penny Paulsberg	Spouse	Interior Design	0				fees	67,788	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 167,114		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1							\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Lutheran Home & Services for the Aged, Inc.
Street Address 800 West Oakton
City / State / Zip Code Arlington Heights, IL 60004
Phone Number (847) 253-3710
Fax Number (847) 253-1427

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	Direct Cost	(1,021)	3	(1,021)		(824)	(824)	1
2	6	Repairs & Maintenance	Direct Cost	76,960	3	76,960		43,640	43,640	2
3	10	Nursing & Medical Records	Direct Cost	39,974	3	39,974				3
4	17	Administrative	Direct Cost	511,912	3	511,912	440,053	413,369	413,369	4
5	19	Professional Fees	Direct Cost	132,497	3	132,497		97,880	97,880	5
6	20	Dues & Subscriptions	Direct Cost	380,925	3	380,925		71,232	71,232	6
7	21	Clerical & General Office	Direct Cost	1,158,924	3	1,158,924	719,906	848,167	848,167	7
8	22	Employee Benefits	Direct Cost	1,487,588	3	1,487,588		1,487,588	1,487,588	8
9	24	Travel & Seminar	Direct Cost	45,278	3	45,278		22,936	22,936	9
10	25	Other Admin. Staff Trans.	Direct Cost	11,940	3	11,940		9,368	9,368	10
11	27	Other - Employee Benefits	Direct Cost	663,607	3	663,607		320,199	320,199	11
12	32	Interest Expense	Direct Cost	27,115	3	27,115		21,896	21,896	12
13	43	Hearthstone / Other	Direct Cost	452,691	3	452,691	391,495			13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,988,390	\$ 1,551,454		\$ 3,335,451	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

NO
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED # 0005090 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Interest on Resident Assets		X								Various	27,863	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 27,863	9
	B. Non-Facility Related*												
10	See Supplemental Schedule											21,896	10
11	Revenue Bonds		X	Residential Unit Construction			24,285,000	28,337,903	08/15/26	Various	1,439,287	11	
12	Non-Care Interest										(565,904)	12	
13	Investment Income										(668,465)	13	
14	TOTAL Non-Facility Related						\$ 24,285,000	\$ 28,337,903			\$ 226,814	14	
15	TOTALS (line 9+line14)						\$ 24,285,000	\$ 28,337,903			\$ 254,677	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

LUTHERAN HOME FOR THE AGED

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0005090

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

LUTHERAN HOME FOR THE AGED

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0005090

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 315,041

B. General Construction Type: Exterior Brick

Frame

Number of Stories

C. Does the Operating Entity?

X(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lutheran Home & Services for the Aged, Inc. - Parent Corporation

Lutheran Community Services for the Aged, Inc. - Family Support Services

Lutheran Foundation for the Aged - Fund Raising Activities

Hearthstone Supportive Apartments - 100 beds, 89,048 square feet

Child Day Care - 6448 square feet

Adult Day Care - 5088 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	871,200	1922	\$ 20,000	1
2	Cemetary	43,560	1896	225	2
3	TOTALS	914,760		\$ 20,225	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LUTHERAN HOME FOR THE AGED

0005090

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	125		1953	1953	\$ 1,242,090	\$ 35,488	50	\$ 35,488	\$	\$ 1,226,121	4
5			1962	1962	82,773	2,365	50	2,365		68,462	5
6	102		1966	1966	1,196,550	34,187	50	34,187		882,048	6
7	126		1973	1973	2,431,047	69,458	50	69,458		1,451,681	7
8	126		1978	1978	3,398,949	97,113	50	97,113		1,757,859	8
	Improvement Type**										
9	RESIDENT GIFT SHOP			1976	10,801	309	50	309		6,018	9
10	LAND IMPROVEMENT			1980	128,110	3,660	50	3,660		61,126	10
11	VARIOUS			1981	1,686,911	48,198	50	48,198		771,159	11
12	VARIOUS			1982	881,456	25,184	50	25,184		385,320	12
13	REMODEL			1983	733,983	20,971	50	20,971		306,177	13
14	WINDOW REPLACEMENT			1984	650,719	18,592	50	18,592		258,428	14
15	REMODEL			1985	335,901	9,597	50	9,597		126,682	15
16	REMODEL			1986	31,815	909	50	909		11,362	16
17	REMODEL COMMON AREA			1987	36,747	1,050	50	1,050		12,389	17
18	REMODEL COMMON AREA			1988	125,105	3,574	50	3,574		39,675	18
19	REMODEL COMMON AREA			1989	5,271	151	50	151		1,566	19
20	REMODEL COMMON AREA			1990	9,600	274	50	274		2,386	20
21	REMODEL COMMON AREA			1991	65,975	1,885	50	1,885		16,966	21
22	REMODEL COMMON AREA			1992	254,620	7,275	50	7,275		59,659	22
23	REMODEL COMMON AREA			1993	60,706	1,734	50	1,734		13,182	23
24	REMODEL COMMON AREA			1994	164,661	4,705	50	4,705		32,463	24
25	REMODEL COMMON AREA			1995	40,474	1,156	50	1,156		7,169	25
26	VARIOUS			1996	40,722	1,165	50	1,165		6,167	26
27	NURSE CALL SYSTEM			1997	7,887	225	50	225		1,081	27
28	DINING ROOM REMODEL			1997	11,492	328	50	328		1,575	28
29	LANDSCAPING			1997	803	23	50	23		94	29
30	NEW WINDOWS			1998	8,814	252	50	252		1,032	30
31	EMPLOYEE EXERCISE AREA			1998	51,115	1,460	35	1,460		6,599	31
32	LOADING DOCK, BASEMENT & BOILERS BLDG F			1998	1,811,044	51,744	35	51,744		172,480	32
33	COMPLETION OF AREA F & RENOVATION OF G			1998	5,065,723	144,735	35	144,735		494,511	33
34	PARKING LOT			1998	32,453	2,164	15	2,164		7,576	34
35	PARKING LOT			1998	326	22	15	22		79	35
36	CONSTRUCTION CONSULTING FEES			1998	16,000	457	35	457		1,638	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	GAZEBO IN COURTYARD	1998	\$ 20,980	\$ 2,098	10	\$ 2,098	\$	\$ 7,867	37
38	STORAGE TANK	1998	8,321	166	10	166		845	38
39	ROOFING	1998	63,194	6,319	10	6,319		79,017	39
40	ROOFING	1999	7,226	206	35	206		635	40
41	CEILING REPLACEMENT	1999	12,363	1,236	10	1,236		3,914	41
42	HVAC - PUMP	1999	4,092	409	10	409		1,398	42
43	AREA E RENOVATION	1999	3,130,000	89,429	35	89,429		268,287	43
44	DIESEL GENERATOR	1999	3,873	111	35	111		379	44
45	AREA G CAPITALIZED INTEREST	1999	55,500	1,586	35	1,586		4,758	45
46	ELECTRICAL	1998	6,190		20	310	310	1,214	46
47	ELECTRICAL	1998	7,624		20	381	381	1,461	47
48	HEATER	1998	3,275		20	164	164	533	48
49	HVAC	1999	4,130		20	207	207	724	49
50	PAINT & WALLPAPER	1999	6,112		20	306	306	1,071	50
51	VINYL CORNER GUARDS	1999	5,444		20	272	272	952	51
52	DOOR	1999	2,161		20	108	108	378	52
53	WIRE FENCED STORAGE	1999	1,848		20	92	92	307	53
54	SPRINKLERS	1999	2,178		20	109	109	354	54
55	BOILER STORAGE	1999	1,297		20	65	65	200	55
56	CUBICLE CURTAINS	1998	1,340		20	67	67	262	56
57	CURTAINS	1998	477		20	24	24	94	57
58	BLINDS, DRAPES, SHOWER CURT HOLDERS	1998	593		20	30	30	110	58
59	CEILING TILES & PAINT GRID	1999	11,500		20	575	575	1,821	59
60	CEILING TILES & PAINT GRID	1999	9,825		20	491	491	1,555	60
61	SHADE & INSTALLATION	1999	750		20	38	38	123	61
62	CABLE	1999	1,364		20	68	68	210	62
63	CABLE	1999	1,016		20	51	51	157	63
64	PERMIT RENEWAL	1998	6,225		20	311	311	1,244	64
65	STORAGE TANK (12937)	2000	9,898	396	25	396		891	65
66	PARKING LOT C (6240)	2000	4,774	318	15	318		661	66
67									67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 24,014,213	\$ 692,684		\$ 696,353	\$ 3,669	\$ 8,572,152	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 24,014,213	\$ 692,684		\$ 696,353	\$ 3,669	\$ 8,572,152	1
2	ENVIRONMENTAL/STORAGE TANK (22163)	2000	16,957	1,130	15	1,130		2,354	2
3	FUEL TANK (300)	2000	230	9	25	9		18	3
4	COST OVERRUNS (1405344)	1999	1,071,996	40,153	35	30,628	(9,525)	107,588	4
5	CAPITALIZED INTEREST	1999	247,614	7,075	35	7,075		20,635	5
6	X-RAY ROOM	1999	16,404	469	35	469		1,526	6
7	GENERATOR (6292)	1999	4,814	193	25	193		482	7
8	ELEVATOR	1999	528	21	25	21		53	8
9	BUILD KITCHEN TRAY LINE (14236)	2000	10,892	311	35	311		777	9
10	KITCHEN PERMITS (2056)	2000	1,573	45	35	45		109	10
11	ROOFING	2000	94,545	2,701	35	2,701		6,528	11
12	BOILER ROOM (2161)	1999	1,653	66	25	66		154	12
13	CIP-INTEREST (61316)	2000	46,913	1,877	25	1,877		3,754	13
14	KITCHEN REMODEL (345,033)	2000	263,985	10,559	25	10,559		21,118	14
15	AREA E REMODEL	2000	25,917	1,037	25	1,037		2,074	15
16	DRAPERIES	1999	16,785	839	20	839		2,448	16
17	KITCHEN REMODEL (216)	1999	165	8	20	8		24	17
18	CLOSETS	1999	17,000	850	20	850		2,409	18
19	CABLE	1999	2,188	109	20	109		309	19
20	CABLE	1999	380	19	20	19		54	20
21	CLOSETS	1999	17,000	850	20	850		2,338	21
22	WIRING	1999	1,588	79	20	79		218	22
23	SECURITY SYSTEM	1999	1,118	56	20	56		150	23
24	CAMERA,CABLES	1999	971	49	20	49		131	24
25	COMPUTER CABLING	1999	3,135	157	20	157		406	25
26	COMPUTER CABLING	1999	483	24	20	24		62	26
27	COMPUTER CABLE	2000	679	34	20	34		79	27
28	COMMUNICATION CABLE	2000	234	12	20	12		28	28
29	LIGHT FIXTURES	2000	7,351	368	20	368		797	29
30	LIGHT FIXTURES	2000	539	27	20	27		58	30
31	LIGHT FIXTURES	2000	5,900	295	20	295		639	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 25,893,750	\$ 762,106		\$ 756,250	\$ (5,856)	\$ 8,749,472	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 25,960,408	\$ 762,133		\$ 759,585	\$ (2,548)	\$ 8,757,533	1
2	KITCHEN PERMIT (2100)	2000	1,607		20	80	80	167	2
3	AIR CONDITIONING	2000	1,118		20	56	56	56	3
4	PAINT GAZEBO	1999	5,782		20	289	289	867	4
5	ELECTRICAL	1999	4,595		20	230	230	690	5
6	ELECTRICAL	1999	575		20	29	29	84	6
7	ARCHITECT FEES	1999	1,412		20	71	71	195	7
8	TILE	1999	598		20	30	30	77	8
9	WALLCOVERING	2000	526		20	26	26	59	9
10	GUARD1 SYSTEM	2000	3,094		20	155	155	374	10
11	PARKING LOT (24460)	2000	18,714	749	25	749	0	1,271	11
12	PARKING LOT (8980)	2000	6,871	275	25	275	0	479	12
13	TRANSFER SWITCHES(13226)	2000	13,226	378	35	378	0	461	13
14	CABLING-ACCTG(9960)	2001	7,620	508	15	508		762	14
15	CABLING	2001	887	59	15	59	(0)	84	15
16	CABLING-ACCTG(8815)	2001	6,744	450	15	450	0	637	16
17	CABLING	2001	770	51	15	51	(0)	72	17
18	CABLING	2001	2,391	159	15	159	(0)	225	18
19	CABLING	2001	660	44	15	44		62	19
20	CABLING	2001	2,397	160	15	160	0	227	20
21	CABLING	2001	1,950	56	35	56	0	65	21
22	CABLING	2001	613	18	35	18	0	19	22
23	CABLING	2001	279	8	35	8	0	9	23
24	CABLING	2001	448	13	35	13	0	14	24
25	CABLING	2001	180	5	35	5	(0)	5	25
26	ARCHITECT FEES	2001	46,189	1,320	35	1,320	0	1,870	26
27	ARCHITECT FEES	2001	5,867	168	35	168	0	238	27
28	PANTRY WORK	2001	79,365	2,268	35	2,268	0	3,213	28
29	J WING IN SERVICE (2570,048)	2001	2,005,151	73,430	35	57,290	(16,140)	87,886	29
30	J WING IN SERVICE (133,475)	2001	104,137	3,814	35	2,975	(838)	4,564	30
31	BUILDING CIP IN SERVICE (2771,178)	2001	2,113,855	79,177	35	60,396	(18,781)	93,386	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 30,398,029	\$ 925,240		\$ 887,902	\$ (37,338)	\$ 8,955,651	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 30,398,029	\$ 925,240		\$ 887,902	\$ (37,338)	\$ 8,955,651	1
2	CREDIT FROM BOND PERMIT FEE	2001	(1,255)	(36)	35	(36)	(0)	(51)	2
3	ELECTRONIC BALLAST	2000	3,230	323	20	162	(162)	324	3
4	ELECTRONIC BALLAST	2000	4,845	485	20	242	(242)	478	4
5	FIXTURES	2000	1,972	197	20	99	(99)	198	5
6	LIGHTING	2000	3,242	324	20	162	(162)	311	6
7	LIGHTING	2000	726	73	20	36	(36)	70	7
8	CHAPEL SHADES	2000	3,313	331	20	166	(166)	318	8
9	FIXTURES	2000	1,273	127	20	64	(64)	117	9
10	FIXTURES	2000	871	87	20	44	(44)	81	10
11	FIXTURES	2000	402	40	20	20	(20)	37	11
12	LIGHT FIXTURES	2000	6,036	604	20	302	(302)	529	12
13	SINKS, FAUCETS	2000	47,000	4,700	20	2,350	(2,350)	3,917	13
14	WINDOWS	2000	19,500	1,950	20	975	(975)	1,625	14
15	EXIT SENSOR-DOCK(4877)	2000	3,731	373	20	187	(187)	327	15
16	LIGHT FIXTURES	2000	5,900	590	20	295	(295)	492	16
17	LIGHT FIXTURES	2000	2,316	232	20	116	(116)	184	17
18	DRAPERIES	2000	21,682	2,168	20	1,084	(1,084)	1,536	18
19	BLINDS	2001	798	80	20	40	(40)	57	19
20	ELECTRICAL WIRING-ACCTG(2274)	2001	1,740	174	20	87	(87)	123	20
21	ELECTRICAL-ACCTG (2678)	2001	2,049	205	20	102	(102)	136	21
22	SECURITY CAMERA(1287)	2001	985	99	20	49	(49)	70	22
23	SINKS	2001	7,373	737	20	369	(369)	461	23
24	AIR CONDITIONING-ACCTG(7600)	2000	5,815	582	20	291	(291)	340	24
25	CABLE-ACCTG(1083)	2000	829	83	20	41	(41)	117	25
26	CABLING	2000	2,386	239	20	119	(119)	298	26
27	HVAC COMPRESSOR	2001	4,397		20	220	220	275	27
28	EXIT DEVICES	2000	1,746		20	87	87	174	28
29	LANDSCAPING(4170)	2000	3,190		20	160	160	306	29
30	ROOFING	2000	1,830		20	92	92	168	30
31	DOORS	2000	5,000		20	250	250	500	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 30,560,951	\$ 940,005		\$ 896,075	\$ (43,931)	\$ 8,969,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

#

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 31,067,723	\$ 949,125		\$ 903,472	\$ (45,653)	\$ 8,977,049	1
2	DOOR SYSTEM *	2002	633		20	5	5	5	2
3	ELECTRICAL *	2001	5,722		20	286	286	286	3
4	GENERATOR (9174) *	2001	7,541		20	346	346	346	4
5	ELECTRICAL *	2001	637		20	32	32	32	5
6	GENERATOR (2118) *	2002	1,741		20	44	44	44	6
7	BOILER / WATER HEATER (1854) *	2002	1,524		20	32	32	32	7
8	WATER HEATER (1097) *	2002	902		20	19	19	19	8
9	HVAC (1290) *	2002	1,060		20	18	18	18	9
10	DA TANK (2784) *	2002	2,288		20	29	29	29	10
11	HOT WATER SYSTEM (1062) *	2002	873		20	18	18	18	11
12	ELEVATOR *	2002	1,865		20	8	8	8	12
13	DOOR *	2002	595		20	2	2	2	13
14	GENERATOR (1050) *	2002	863		20	4	4	4	14
15	LANDSCAPING (1553) *	2002	1,277		20	11	11	11	15
16	PUNCH TUBES *	2002	1,960		20	16	16	16	16
17	LANDSCAPING (4578) *	2001	3,763		20	16	16	16	17
18	EXIT SIGN *	2002	683		20	17	17	17	18
19	LANDSCAPING (1724) *	2002	1,417		20	14	14	14	19
20	GAZEBO (3435) *	2001	2,824		20	141	141	141	20
21	PAINTING / DECORATING *	2002	4,675		20	97	97	97	21
22	PAINTING / DECORATING *	2002	4,464		20	93	93	93	22
23	PUMP (2547) *	2002	2,094		20	17	17	17	23
24	H WING RENOVATION (2,009,543)	2001	1,651,844		20	165,184	165,184	165,184	24
25	ENCLOSURE - ACROSS FROM FOLDING ROOM (3150)	2002	2,402		20	60	60	60	25
26	CARPETING WITH VINYL BASE	2002	17,263		20	288	288	288	26
27	SINKS, COUNTERS, WARDROBES	2002	23,402		20	390	390	390	27
28	ORTRONICS MODULE PATCH PANEL (153)	2002	116		20	2	2	2	28
29	BLOWER, HEATER, PENTHOUSE (2355)	2001	1,796		20	60	60	60	29
30	SHUT OFF VALVES & PIPE WRAP (3802)	2001	2,900		20	85	85	85	30
31	PARTIAL BILLING - EML (20,980)	2002	16,004		20	267	267	267	31
32	SPEAKERS FROM OVERHEAD PAGE SYSTEM (4087)	2002	3,118		20	52	52	52	32
33	SPEAKERS FROM OVERHEAD PAGE SYSTEM (1183)	2002	902		20	15	15	15	33
34	TOTAL (lines 1 thru 33)		\$ 32,836,871	\$ 949,125		\$ 1,071,139	\$ 122,014	\$ 9,144,717	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 32,836,871	\$ 949,125		\$ 1,071,139	\$ 122,014	\$ 9,144,717	1
2	SECURITY SYSTEM (1125)	2002	858		20	14	14	14	2
3	SECURITY SYSTEM (907)	2002	692		20	12	12	12	3
4	H WING RENOVATION - ACCTG & COMPUTER (165,000)	2002	125,862		20	12,586	12,586	12,586	4
5	5 A/C UNITS NURSING PAVILION	2002	283,900		20	28,390	28,390	28,390	5
6	MASONRY WORK G-WING	2001	20,760		20	519	519	519	6
7	MASONRY WORK E-WING	2001	17,695		20	442	442	442	7
8	MASONRY WORK E-WING	2001	9,840		20	246	246	246	8
9	MASONRY WORK H-WING (15,930)	2001	13,094		20	327	327	327	9
10	MASONRY WORK G-WING	2001	26,965		20	674	674	674	10
11									11
12									12
13									13
14									14
15									15
16									16
17	* Not on 6/30/02 capital projection								17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 33,336,537	\$ 949,125		\$ 1,114,350	\$ 165,225	\$ 9,187,927	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$5,235,819	\$787,101	\$787,101	\$	10	\$5,402,656	71
72	Current Year Purchases	437,378	65,751	70,855	5,104	10	70,855	72
73	Fully Depreciated Assets	1,716,400				10	1,716,400	73
74								74
75	TOTALS	\$7,389,597	\$852,852	\$857,956	\$5,104		\$7,189,911	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Ford Club Wagon	1997	\$100,711	\$	\$	\$	5	\$100,711	76
77	Patient Care	2002 Goshen Bus	2001	50,932	8,489	8,489		4	8,489	77
78	Housekeeping	2000 Ford Truck Explorer	2001	18,793	1,566	1,566		4	1,566	78
79										79
80	TOTALS			\$170,436	\$10,055	\$10,055	\$		\$110,766	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$40,916,795	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,812,032	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,982,361	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$170,329	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$16,488,604	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	see attached schedule	\$12,906,230	\$216,968	\$1,069,846	86
87					87
88					88
89					89
90					90
91	TOTALS	\$12,906,230	\$216,968	\$1,069,846	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 1,533
- Description: Nursing Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$
13. /2004 \$
14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐

 YES

☒

 NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 234,763	\$		\$ 234,763	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			203,456			203,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			601,679			601,679	4
5	Physician Care	39 - 03	visits			7,422			7,422	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				808,827		808,827	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					21,230	304,388		325,618	13
14	TOTAL			\$		\$ 1,068,550	\$ 1,113,215		\$ 2,181,765	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,988,457	\$ 2,890,398	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,930,995	1,948,418	3
4	Supply Inventory (priced at)	243,626	243,626	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	709,188	3,547,796	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,872,266	\$ 8,630,238	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,096,361	11,718,025	12
13	Land	20,225	20,225	13
14	Buildings, at Historical Cost	45,342,021	45,342,021	14
15	Leasehold Improvements, at Historical Cost	349,382	349,382	15
16	Equipment, at Historical Cost	9,137,664	9,137,664	16
17	Accumulated Depreciation (book methods)	(17,357,855)	(17,357,855)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds		2,856,096	21
22	Other Long-Term Assets (specify) Financing Cost	698,671	698,671	22
23	Other(specify): See Supplemental Schedule	1,538,301	6,579,652	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,824,770	\$ 59,343,881	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 49,697,036	\$ 67,974,119	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,353,208	\$ 1,463,913	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	265,000	265,000	29
30	Accrued Salaries Payable	1,334,148	1,761,946	30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	444,188	444,188	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	7,135,224	533,995	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,531,768	\$ 4,469,042	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	28,072,903	28,072,903	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	1,538,302	1,733,774	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 29,611,205	\$ 29,806,677	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 40,142,973	\$ 34,275,719	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,554,063	\$ 33,698,400	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 49,697,036	\$ 67,974,119	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,814,850	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,814,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,260,786)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,260,786)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,554,064	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 24,863,390	1
2	Discounts and Allowances for all Levels	(4,762,825)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,100,565	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,845,037	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,845,037	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	161,019	13
14	Non-Patient Meals	62,640	14
15	Telephone, Television and Radio	51,796	15
16	Rental of Facility Space	1,044,823	16
17	Sale of Drugs	1,113,951	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,659	19
20	Radiology and X-Ray	4,601	20
21	Other Medical Services	15,051	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,475,540	23
	D. Non-Operating Revenue		
24	Contributions	571,854	24
25	Interest and Other Investment Income***	49,755	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 621,609	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	349,490	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 349,490	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,392,241	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	6,909,681	31
32	Health Care	9,370,229	32
33	General Administration	6,017,320	33
	B. Capital Expense		
34	Ownership	3,526,667	34
	C. Ancillary Expense		
35	Special Cost Centers	2,654,365	35
36	Provider Participation Fee	174,765	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,653,027	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,260,786)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,260,786)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number LUTHERAN HOME FOR THE AGED

0005090

Report Period Beginning:

07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,010	2,115	\$ 89,877	\$ 42.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	106,040	115,672	2,478,861	21.43	3
4	Licensed Practical Nurses	23,090	25,889	527,102	20.36	4
5	Nurse Aides & Orderlies	347,726	389,875	4,850,039	12.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,716	10,359	170,309	16.44	8
9	Activity Director					9
10	Activity Assistants	21,315	26,016	323,383	12.43	10
11	Social Service Workers	10,252	11,929	219,739	18.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	103,581	124,456	1,303,052	10.47	15
16	Dishwashers					16
17	Maintenance Workers	43,323	50,659	772,536	15.25	17
18	Housekeepers	78,240	90,647	793,162	8.75	18
19	Laundry	10,642	12,484	113,354	9.08	19
20	Administrator	1,725	1,868	95,411	51.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,002	9,570	177,259	18.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,150	3,923	63,409	16.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	28,478	33,741	406,431	12.05	33
34	TOTAL (lines 1 - 33)	796,290	909,203	\$ 12,383,924 *	\$ 13.62	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	16,809	09-03	36
37	Medical Records Consultant	monthly	3,460	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,335	10-03	39
40	Physical Therapy Consultant	204	11,213	10a-03	40
41	Occupational Therapy Consultant	50	2,736	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,683	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dietary - Temp. Labor		4,002	01-03	47
48	Pastoral Assistance	monthly	4,800	12-03	48
49	TOTAL (lines 35 - 48)	285	\$ 50,038		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3	52	10-03	52
53	TOTAL (lines 50 - 52)	3	\$ 52		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		LUTHERAN HOME FOR THE AGED		STATE OF ILLINOIS				Page 23
		#	0005090	Report Period Beginning:	07/01/01	Ending:	06/30/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Dues paid by related party. Yes

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 196,240

Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$ 170,820

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 62,640

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c.

What percent of all travel expense relates to transportation of nurses and patients?

None

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?

Yes

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

KPMG

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

Yes

If no, please explain.

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees